



Wireless Service Request



Department Information	1 Department Name	2 Department Address
	3 NCIC Primary ORI (for LEADS access only)	

Billing Information	4 Accounting Unit #	5 Billing Contact Name	Telephone
	6 Establish New Accounting Unit # <input type="checkbox"/> Yes, complete billing information in boxes 5 and 7 FEIN # _____ - _____ <input type="checkbox"/> No	7 Billing Address	

IWIN Coordinator	8 IWIN Coordinator Name		9 IWIN Coordinator Address (Software will be shipped to this address)	
	10 Telephone	11 Fax		
	12 Internet email address			
	* State Agencies Only *			
	13 Telecom Coordinator Name	14 Telecom Coordinator Telephone		

Terms and Conditions	<p>Use of the IWIN network is strictly for official business only. CMS reserves the right to monitor any traffic on the network and notify offending agencies of any improprieties found. CMS imposes no restrictions on authorized usage of the IWIN network as long as usage is within the guidelines of the CDMA plan subscribed too.</p> <p>Each IWIN agency is required to designate an agency IWIN Coordinator. The coordinator will be the primary interface between IWIN and the agency in matters pertaining to service and equipment orders, reporting trouble calls, attending all IWIN related informational sessions and meetings, receiving messages sent to IWIN coordinators via IWIN, and ensuring all IWIN users are aware of and adhere to the IWIN policies and procedures as well as any other duties defined in the IWIN Coordinator Responsibilities document.</p> <p>For a copy of the official IWIN Coordinator Responsibilities or the IWIN Policies and Procedures please refer to the BCCS website/IWIN page at http://bccs.illinois.gov/BCCScatalog/Communicationservices.htm</p>	
	15 Chief Administrator / Telecom Coordinator Name	17 I agree to the terms and conditions listed on this form.
	16 Title of Chief Administrator / Telecom Coordinator	Chief Administrator / Director Signature _____ Date _____

CMS Use Only	
P.O. #	_____
Activation Date	_____
Software Shipped Date	_____
Version	_____
User Reg.	_____
Fax IP List	_____
Date Received	

ISP Use Only	
CDC	_____
ORI	_____
CDC Entry Date	_____
Date Received	_____
LEADS Agreement:	() On-file ISP () Attached

**Customer Service Center
at 1-800-366-8768
with any questions.**

15 Chief Administrator / Telecom Coordinator Name	17 I agree to the terms and conditions listed on this form.	18 Control # _____
16 Title of Chief Administrator / Telecom Coordinator	Chief Administrator / Director Signature _____	Emergency CDC _____
	Date _____	